TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Patient Care Injury Clinic

Respondent Name
Retailers Casualty Insurance Company

MFDR Tracking Number
M4-16-0588-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
November 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel that our facility should be paid according to the fee schedule guidelines."

Amount in Dispute: $754.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… no reimbursement is owed to Requestor because they were not an authorized health care provider."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21 & 24, 2015	Physical Therapy	$754.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.021 sets out the requirements for entitlement to medical benefits.
3. Texas Government Code §311.016 defines the code construction process.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment. Services are disallowed as not authorized.
   - 18 – Exact duplicate claim/service. Duplicate charge.

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code P12 – "WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT. SERVICES ARE DISALLOWED AS NOT AUTHORIZED." Texas Labor Code §408.021 requires that "Except in an emergency, all health care **must** be approved or recommended by the employee's treating doctor." According to Texas Government Code 311.016(3) states that, unless a different construction is expressly provided, the term "'must' creates or recognizes a condition precedent." For this reason, the requestor must support that treatment was approved or recommended by the employee's treating doctor in order to be entitled to medical benefits.

Review of the submitted information does not support that the treatment in question was approved or recommended by the employee's treating doctor. Therefore, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	January 15, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.